California Welfare and Institutions Code (WIC)

1. California uses the definition of “developmentally disabled” and “substantial disability” for the target population of this waiver, as defined in the California Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, §4512

   As used in this division: “Developmental disability” means a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual…(Link)

   http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4512.&lawCode=WIC

2. California uses the definition of “medical necessity” as set forth in the Welfare and Institutions Code, §14059.5

   A service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. (Link)

   http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14059.5

3. California uses the definition of “Waiver Personal Care Services” as outlined in the following Welfare and Institutions Code sections: Welfare and Institution Code §14132.97

   (a) (1) For purposes of this section, “waiver personal care services” means personal care services authorized by the department for persons who are eligible for either nursing or model nursing facility waiver services.

   (2) Waiver personal care services shall satisfy all of the following criteria:

   (A) The services shall be defined in the nursing and model nursing facility waivers.

   (B) The services shall differ in scope from services that may be authorized under Section 14132.95 or 14132.952.

   (C) The services shall not replace any hours of services authorized or that may be authorized under Section 14132.95 or 14132.952…..(Link)

   http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.97.&lawCode=WIC

Waiver Personal Care Services are defined in the HCB Alternatives Waiver in Appendix C: Participant Services, C-1/C-3: Service Specification, Service: Personal Care/Waiver Personal Care Services.

4. DHCS Audits & Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including the Home and Community Based (HCB) Alternatives Waiver. All claims submitted by waiver and State Plan providers are subject to random review regardless of provider type, specialty, or service rendered. Under Welfare and Institutions Code, Section §14124.2:

   (a) (1) During normal working hours, the department may make any examination of the books and records of, and may visit and inspect the premises or facilities of, those identified in paragraphs (2) and (3), that it may deem necessary to carry out the provisions of this chapter or Chapter 8 (commencing with Section 14200) and regulations adopted thereunder, or the law under which the department or its agents or contractors administer any other health care program…(Link)

   http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14124.2.&lawCode=WIC

5. Welf. & Inst.Code § 14132. Schedule of benefits

   The following is the schedule of benefits under this chapter:

   . . .

   (t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers. (Link)
   http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.&lawCode=WIC

6. Welf. & Inst.Code § 14132.991

   § 14132.991. Renewal of Nursing Facility/Acute Hospital Transition and Diversion Waiver; permissible actions; expedited contract process; implementation

   (a) When renewing the Nursing Facility/Acute Hospital Transition and Diversion Waiver, as authorized by subdivision (t) of Section 14132, the director may take the following actions, among others:

(1) Contract with one or more organizations, referred to as a care management contractor, qualified to provide or arrange for delivery of care management and waiver services, including, but not limited to, personal needs assessments, and arranging for services available through public and private agencies, including services available under the waiver, for the waiver participants and applicants. The contract with the care management contractor, the care management contract, may require the care management contractor or their subcontractor, or both, to do all of the following, among other things:

(A) Provide, arrange for, or subcontract with community-based providers for the provision of, waiver services to waiver participants.

(B) Recognize program and service linkages, coordinate service delivery mechanisms and promote prevention of avoidable institutional placement, emergency room visits or inpatient hospital stays, or both, and coordination between health, social, and long-term services and supports by person-centered care planning.

(C) Provide or arrange for, care management to each waiver participant to stabilize their health care, and provide access to home- and community-based services, including managing and anticipating episodes of medical crisis in which transitional care management is needed.

(D) Carry out the waiver's person-centered model of care, pursuant to the requirements set forth in Sections 441.720, 441.725, and 441.540 of Title 42 of the Code of Federal Regulations.

(E) Submit all information and reports required by the department, including, but not limited to, annual financial statements in the timeframe specified by the department.

(F) Pay any providers of waiver services who are not directly employed by or contracted with the care management contractor no less than the rates specified in the waiver or the department's fee schedule, whichever is less, for the provider type.

(G) Bill the department, at the rate established by the state, for all services the care management contractor provides to waiver participants, directly or through a subcontractor or other direct service provider.

(H) Comply with the requirements of the waiver, including any other requirements established by the department regarding waiver operations, including, but not limited to, requirements regarding care coordination. These requirements may be set forth in the care management contract, care management manual, all-county letters, plan letters, plan or provider bulletins or policy letters, or similar instructions.

(2) Propose that the waiver provide for achievement of annual cost neutrality in the aggregate to allow enrollment and authorization of waiver services based on the medical necessity of the waiver services on a case-by-case basis.

(3) Expand the number of waiver slots up to 5,000 additional slots, the director may seek federal approval to amend the waiver to add additional slots or make changes to the waiver model with approval from the Department of Finance.

(4) Require care management contractors to enroll at least 60 percent of all total annual enrollments from either of the following:

(A) Hospital, nursing facility, or other institutional settings assisting members with transitions back to the home or community, or both, setting.

(B) Individuals who had been continuously receiving in home care services, of the type offered under the waiver, under the Early and Periodic Screening, Diagnosis, and Treatment State Plan benefit, California Children Services or Pediatric Palliative Care programs for children, for at least the prior three months but have at the time of transition exceeded the age limit for that benefit.

(5) If the director determines that the care management contractor is not fiscally solvent, or is in danger of becoming fiscally insolvent, the director has the option to immediately terminate the contract with the care management contractor.

(6) Terminate or refuse to renew, in whole or in part, a care management contract when the director determines that the action is necessary to protect the health of the beneficiaries or funds appropriated to the Medi-Cal program.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, plan or provider bulletins, policy letters, or other similar instructions, without taking regulatory action.

(c) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and shall be exempt from the review or approval of any division of the Department of General Services.

(d) The department shall implement this section only to the extent it can demonstrate federal cost neutrality as required under the terms of the waiver, and only to the extent any necessary federal approvals are obtained and federal financial participation is available. (Link)

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.991.&lawCode=WIC